for Bedfordshire and Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **The Chief Executive** **Luton & Dunstable University Hospital NHS Foundation Trust** **Lewsey Road** **Luton LU4 0DZ**
1	**CORONER** I am IAN PEARS, Acting Senior Coroner, for the coroner area of Bedfordshire & Luton
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 17th February 2016 I commenced an Investigation into the death of PATRICK NEIL **WOODS** aged 45. The Investigation concluded at the end of the Inquest on 15th June 2017. The Conclusion of the inquest was while being treated for pneumonia, the deceased required treatment with an anaesthetic machine. The hospital provided a machine which could falsely appear to be delivering fresh oxygen. The hospital failed to ensure that the machine could only be used by those that had been trained on it and failed to ensure that clinicians had been trained on all the machines that they were likely to come into contact with. The clinicians did not notice the deteriorating readings of FiO_2. The deceased died from hypoxic brain injury. His death could have been avoided if the machine had been identified as one that the clinicians had not been trained on. The medical cause of death was: I (a) Hypoxic Brain Injury I (b) Multi Organ Failure II Bilateral Community Acquired Pneumonia
4	**CIRCUMSTANCES OF THE DEATH**

Senior Coroner, The Court House, Woburn Street, AMPTHILL, Bedfordshire, MK45 2HX
Tel 0300-300-6559 | Fax 0300-300-8267

	On Thursday 11th February 2016 the deceased was admitted to the Luton & Dunstable Hospital with a history of a cough since the Monday. During the early hours of 12th February his condition was deteriorating. He was transferred to Recovery A-D and a Dräger Tiro Anaesthetic Machine was set up for use. The clinicians were not aware that the machine was not delivering air. The clinicians were not aware that they did not know that the machine was capable of recycling the patient's air. Subsequently the deceased went into cardiac arrest. On 15th February 2016 he died from hypoxic brain injury at the Luton & Dunstable Hospital
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (1) The extent of the equipment portfolio held by the Hospital seemed to be unknown (2) Without the knowledge of the equipment held, no potentially dangerous equipment can be identified (3) Without the knowledge that there is equipment that could potentially kill a patient, no risk assessment can be undertaken (4) Without a risk assessment, no action can be taken to prevent further injury to patients or fatalities
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as Chief Executive of the Luton & Dunstable Hospital have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **20th August 2017**. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION**

	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated 19th June 2017 ..... IAN PEARS Acting Senior Coroner Bedfordshire & Luton

for Bedfordshire and Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **Dräger** **c/o DAC Beachcroft LLP** **1 Minister Court** **Mincing Lane** **London EC3R 7AA**
1	**CORONER** I am IAN PEARS, Acting Senior Coroner, for the coroner area of Bedfordshire & Luton
2	**CORONER'S LEGAL POWERS** I make this Report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 17th February 2016 I commenced an Investigation into the death of PATRICK NEIL **WOODS** aged 45. The Investigation concluded at the end of the Inquest on 15th June 2017. The Conclusion of the Inquest was while being treated for pneumonia, the deceased required treatment with an anaesthetic machine. The hospital provided a machine which could falsely appear to be delivering fresh oxygen. The hospital failed to ensure that the machine could only be used by those that had been trained on it and failed to ensure that clinicians had been trained on all the machines that they were likely to come into contact with. The clinicians did not notice the deteriorating readings of FiO_2. The deceased died from hypoxic brain injury. His death could have been avoided if the machine had been identified as one that the clinicians had not been trained on. The medical cause of death was: I (a) Hypoxic Brain Injury I (b) Multi Organ Failure II Bilateral Community Acquired Pneumonia

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4	**CIRCUMSTANCES OF THE DEATH** On Thursday 11th February 2016 the deceased was admitted to Luton & Dunstable Hospital with a history of a cough since the Monday. During the early hours of 12th February his condition was deteriorating. He was transferred to Recovery A-D and a Dräger Tiro Anaesthetic Machine was set up for use. The clinicians were not aware that the machine was not delivering air. The clinicians were not aware that they did not know that the machine was capable of recycling the patient's air. Subsequently the deceased went into cardiac arrest. On 15th February 2016 he died from hypoxic brain injury at the Luton & Dunstable Hospital
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) The evidence of 4 clinicians at the inquest would suggest that the training by Dräger was not effective.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe **Dräger** have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **20th August 2017**. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted]

	I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this Report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated 19th June 2017  ..... IAN PEARS Acting Senior Coroner Bedfordshire & Luton